STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295050	A. BUILDING _____ B. WING _____	C 08/01/2007

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F 225	Continued From page 1 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on policy review, record review, interview and observation, it was determined that the facility failed to ensure that an allegation of abuse was investigated in accordance with the facility's abuse and neglect policy for 1 of 3 residents (Resident #1) and failed to thoroughly investigate and report a potentially abusive situation for 1 of 3 residents (Resident #3) in accordance with the facility's abuse and neglect policy. Findings include: Review of the facility's abuse and neglect policies on 7/19/07, revealed the following: 1) The facility will identify, correct and intervene in situations in which abuse, neglect and/or	F 225	**F225** I: Corrective actions for the residents involved are as follows: Resident #1 shows no ill will in regards to the allegations made by his former roommate (Resident #2). Residents #1 & #2 are no longer roommates. Resident #2 was referred to and admitted to Senior Bridges for a period of time in an attempt to develop a behavior modification program. He has since been readmitted to Life Care Center of Reno and awarded a private room to minimize delusional thoughts regarding roommates. He is receiving behavior management medications, which are effective for him. Resident #3 has exhibited no adverse physical effects as a result of the incident with Resident #2. II: The facility will take the following steps to identify other residents having the potential to be affected and will implement corrective actions as indicated: Residents with incidents in the facility have the potential to be affected by this alleged deficiency. Incidents of the past 30 days will be reviewed to validate that they were investigated and reported to State Agencies as required by State	

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F 225	Continued From page 2 misappropriation of resident property were likely to occur. This included staff recognition of inappropriate behaviors, and monitoring residents whose needs or behaviors might lead to conflict or neglect. 2) The interdisciplinary team would consider the possibility of abuse or neglect and proceed with investigations. 3) Incidents of suspected abuse or neglect would be thoroughly investigated to include questioning staff, family, visitors, the resident and other residents who might have knowledge of the incident. Appropriate corrective actions will be taken upon completion of the investigation. 4) Residents would be protected from harm during the investigation. 5) It was the responsibility of all staff to report resident abuse, mistreatment, or neglect directly to the director of nursing and/or the executive directors or their designees as well as to the appropriate state agencies. The state requirements were that a completed investigation result would be sent to the state agencies within five working days. The state agency received a faxed report on 6/26/07 that an allegation of inappropriate touching by Resident #1 was reported by Resident #2. The state agency received a second faxed summary of the completed investigation which was dated 6/30/07. This summary indicated that the allegation was unsubstantiated. The summary indicated that the event occurred in the early morning hours of 6/26/07. Resident #1 and Resident #2 were interviewed by staff at the facility on 6/26/07 and both denied the event. No action was taken by the facility except that due to "other significant behaviors" exhibited by Resident #2, he was	F 225	and Federal regulations. III: Measures taken and systemic changes in place to prevent recurrence include: 1) In-service line staff and management personnel regarding abuse reporting policy and procedures, investigation of alleged abuse and incidents, and interviewing techniques in order to protect residents from retaliation. 2) The interdisciplinary team has been educated regarding resident on resident events and the importance of reporting. 3) The DON and interdisciplinary team will view the web-cast put out by CMS titled "Investigative Techniques." It is intended to: "Provide instructions on techniques for developing and implementing an effective Investigative plan." IV: The Performance Improvement Committee will review incidents and investigations on a monthly basis to ensure timely reporting, investigation completion, and provision of resident safety until threshold is met. V: Director of Nurses and Executive Director VI: September 17, 2007	

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F 225	Continued From page 3 transferred to a senior mental health inpatient facility for evaluation and treatment. Resident #1: This resident's primary diagnoses included restless legs and difficulty walking. He required a wheelchair for ambulation and was oxygen dependant. He required assistance with most activities of daily living (ADLs). He preferred to not interact with other residents or staff unless it was his choice. His primary language was English. Resident #2: This resident's primary diagnoses included dementia, hypertension, anxiety state, and hallucinations. His primary language was Spanish and Spanish-speaking staff were utilized for communication. Resident #2 was ambulatory and required only minimal assistance with ADLs. Documentation revealed that Resident #2 wandered frequently, and often was up for long periods throughout the night. Resident #1 and Resident #2 had been roommates since 3/3/07. Review of the record revealed an entry in Resident #2's record written at 2:00 AM on 6/26/07, by licensed practical nurse (LPN) #1. He documented that he had received third person information that Resident #2 had told certified nursing assistant (CNA) #1 that he had been fondled by Resident #1. An interview with LPN #1 on 8/1/07 at 8:10 AM, confirmed that he was the author of the above entry. He stated the time of the entry (2:00 AM) was when he wrote the entry, but this was not the time of the event. LPN #1 stated that at approximately 11:45 PM on 6/25/07, Resident #2	F 225		

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F 225	Continued From page 4 did not want to go to bed to sleep. At this time, LPN #1 was told by an unidentified CNA that she had overheard an earlier conversation with Resident #2 and another CNA (CNA #1). LPN #1 could not recall which CNA was the individual who told him about the overheard conversation. He stated that he was told that Resident #2 told CNA #1 that he had been fondled by his roommate (Resident #1). LPN #1 offered Resident #2 another room to sleep in, but this was refused. Resident #2 stated he did not want to be raped so he was going to stay up. LPN #1 also informed the resident that the facility would investigate immediately. LPN #1 contacted CNA #1 and was told that Resident #2 had reported this to her at the beginning of the evening meal, approximately 5:00 PM, and she had informed the evening shift nurse at that time. LPN #1 also informed the Director of Nursing (DON), who was present in the facility; at this time and filled out an incident report with the above information. The DON had been called to the facility because of a staff injury. The DON was interviewed on 7/19/07 and 8/1/07. She confirmed that she was informed by LPN #1 about the incident approximately around midnight of 6/25-26/07 and thought the allegation had just occurred. She had not been contacted earlier by any other staff regarding this event. She also confirmed that she was present at the facility until around 8:00 AM on 6/26/07. The DON did not initiate any investigation, but did observe the two residents at approximately 4:00 AM. They were both in the assisted dining room. At that time she stated that she did not observe any avoidance or aggressive behaviors between the two residents. The DON stated that she delegated the	F 225		

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F 225	Continued From page 5 investigation to the social worker and the nurse manager of Station 2 when she left the facility the morning of 6/26/07. The social worker note of 6/26/07 documented that Resident #1 was told that Resident #2 was saying Resident #1 was touching him. Resident #1 denied this. The social worker stated that she did not interview any staff members. There was no separate witness statement by Resident #1 in the facility investigation report. An interview with the nurse manager of Station 2 was conducted on 7/19/07. The charge nurse acknowledged that she interviewed Resident #2, but did not investigate the incident. Nor was she aware that the event happened approximately five to six hours before it was reported by LPN #1. The charge nurse also denied interviewing any staff members identified by LPN #1's written statement. There was no separate witness statement by Resident #2 in the facility investigation report. A telephone interview with LPN #2 was conducted on 8/1/07. LPN #2 confirmed she was aware of the facility's abuse and neglect policy. She stated that around 5:00 PM on 8/25/07, she was told by CNA #1 that Resident #2 had reported that Resident #1 had touched him. She stated that it was around 5:00 PM because she was passing medication, but she did not interrupt her medication pass to assess Resident #2. She stated that she could see Resident #2 sitting at the nurses station and he did not appear to be in any distress. LPN #2 also confirmed that it was approximately one hour before she completed her medication pass and then inquired about the event with Resident #2 with a translator. She also	F 225		

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F 225	Continued From page 6 stated that she had brought Resident #1 to the nurses' station and asked him if he did what Resident #2 said. Resident #1 denied this. LPN #2 acknowledged that during this conversation, Resident #2 was sitting at the nurses' station. She then asked Resident #2 if Resident #1 had touched him, and he denied it. LPN #2 stated that she felt Resident #2 was delusional and the event never happened and that was why she did not report the allegation to the DON. A telephone interview was conducted with CNA #1 on 8/1/07. She stated that she was assigned to Station 1 of that facility that evening. She was asked to come and translate because Resident #2 was trying to tell the CNAs of Station 2 something and they could not understand him. This was at the beginning of the evening meal, approximately around 5:00 PM. When asked if she spoke Spanish, CNA #1 stated it was her primary language. She introduced herself to Resident #2 and asked what was wrong. He said he did not want to go into the main dining room or back to his room. He stated his roommate touched him and pointed to his groin. CNA #1 stated her impression was that Resident #2 was embarrassed. CNA #1 stated that she told LPN #2 that something happened to Resident #2, but did not want to go into detail because LPN #2 was in the assisted dining room, where other residents could have overheard her conversation. CNA #1 stated she informed the CNAs on Station 2 what had happened, but did not remember who was working. CNA #1 then returned to Station 1. CNA #1 stated she was not called back to translate for Resident #2 any more that evening. She could give no explanation why she did not notify the DON about the allegation.	F 225		

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F 225	Continued From page 7 The facility failed to demonstrate that they followed their own abuse and neglect policies because: 1) There was no documentation to demonstrate that the facility investigated why this event was not reported to the DON when it was first reported at 5:00 PM on 6/25/07. The written statement from LPN #1 indicated the event happened around dinner. 2) There was no written documentation that any staff members were interviewed although the written statement from LPN #1 and the verbal statement from CNA #1 indicated at least two to three other staff members were aware of the allegations. 3) There was no evidence that resident safety and confidentiality were protected per the facility policy. It was documented by the social worker that Resident #1 was told who reported the allegation. It was also verbally confirmed by LPN #2 that Resident #1 and Resident #2 were both present at the nurses' station when they were asked about the allegations. 4) The facility could not provide evidence that this allegation was thoroughly investigated because there was no documentation provided to show that any of the interdisciplinary team were accountable for the coordination of the investigation. 5) The facility staff could not demonstrate how they protected Resident #1 or Resident #2 from possible retaliation: either Resident #1's reactions from being accused of inappropriate sexual conduct or Resident #2's perception that Resident #1 was a threat. On 7/19/07 during the interview with the nurse manager for Station 2, it was revealed that Resident #2 had been transferred to a senior	F 225		

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F 225	Continued From page 8 mental health in-patient facility on 6/28/07. This was due to the facility's concern that they could not keep other residents safe from Resident #2's behaviors. Resident #2 exhibited behaviors that indicated he thought some of the female residents were his wife, and would touch them on their arms or clothes. However, in the early morning hours of 6/28/07, Resident #2 was found on the floor of a female resident's room. The female resident (Resident #3) was on the floor next to him. Although neither resident could explain what happened, facility staff thought that Resident #2 went into Resident #3's room, possibly lifting her out of her bed and was carrying her out of her room. There were no injuries observed on either resident, so the facility staff thought perhaps Resident #2 placed rather than dropped Resident #3 onto the floor. Review of Resident #3's record revealed that this resident's primary diagnoses included Alzheimer's, senility, and arthropathy. An annual assessment was performed on 6/14/07 indicated Resident #3 required excessive assistance requiring two staff for all ADLs and had poor balance. She also had poor cognition, and she was not being able to understand or be understood. Care plans indicated that the resident was unable to make her needs known. She would track sound with her eyes at times and required to be fed. This was related to the "severe cognitive deficits related to Alzheimer's." The care plan addressing activities documented that Resident #3 was passive in all activities, disoriented/confused and lethargic most of the day. She was non-verbal. Full side rails times two were in place. Documentation in Resident #3's record revealed	F 225		

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that she was discovered on the floor at 1:15 AM on 6/28/07, "after a male resident called for help and was on the floor near the door." The side rails of her bed were up. The resident was not able to relate what happened.

Documentation in Resident #2 ' s record revealed that at 1:15 AM on 6/28/07, he yelled out from another resident's room and was found lying on the floor next to the female resident. Resident #2 could not explain what happened.

Both entries were written by Registered Nurse (RN) #1. A telephone interview with RN #1 was conducted on 8/1/07 at 9:30 AM. When asked to recall the events of 6/27-28/07, RN #1 stated that she was walking down the 208-217 room hall to administer a pain medication to a resident. Resident #2 did not reside on this hall . Resident #2 approached her and started talking, but she could not understand him. She told him "no comprende" and proceeded to continue down the hall. She did not attempt to find out what Resident #2 wanted.

She returned to the nurses' station. She denied hearing any noises, but then heard a man yelling. When she went to investigate, she found both Resident #2 and Resident #3 lying in the area just inside Resident #3's room. Both were on their left side facing the wall. Resident #3 was just lying there, not making any sound. When asked if Resident #3 could have gotten out of bed by herself, RN #1 denied this possibility. She also stated that both side rails were up. RN#1 stated that staff put Resident #3 back into bed and that Resident #2 was taken to the nurses' station. When Resident #2 was asked what happened by a CNA who spoke Spanish, his reply was "what

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F 225	Continued From page 10 floor, what lady?" Since this was the room next to where RN #1 delivered the pain medication, she thought maybe Resident #2 followed her down the hall but could not be sure. She also could not recall if walking past this room upon her return to the nurses station that she saw or heard anything unusual. The DON was notified by RN #1 and incident reports were completed. Review of the incident/accident data entry forms revealed that there was no documentation that both residents were found lying on the floor of Resident #3's room. There was no evidence in the incident documentation that indicated the two incidents were related. There was no evidence of any interviews of staff to assist in determining what might have happened. Interviews with both the Administrator and the DON, on 7/19/07 and 8/1/07 revealed that the incident was identified as a fall with no injuries even though they acknowledged that Resident #3 could not have gotten out of bed by herself. When asked why they did not report this resident on resident event to the Bureau of Licensure and Certification, they stated that a fall with no injuries was not a reported event. The Administrator and the DON stated that the facility did not interpret this event as a resident on resident event but also confirmed that this act was what determined that Resident #2 needed to be transferred to an inpatient facility for mental health evaluation because his behaviors placed other residents at risk. The facility failed to demonstrate that they followed their own abuse and neglect policies	F 225		

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F 225	Continued From page 11 because: 1) The facility failed to demonstrate that they considered this event as a possible resident on resident event, which was required to be reported to the state agency, although they identified that Resident #2 was a risk to the safety of the other residents. 2) There was no evidence that the facility followed their abuse and neglect policy to thoroughly investigate the event or interview staff members to assist in determining what might have happened or why RN #1 did not attempt to have someone find out what Resident #2 wanted.	F 225		